FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023093

Facility Name: BALLARD NURSING CENTER

Address: 9300 BALLARD ROAD (Number) DES PLAINES (City) 60016 (Zip Code)

County: COOK

Telephone Number: (847) 294-2300 **Fax #** (847) 299-4012

IDPA ID Number: 36-2897326

Date of Initial License for Current Owners: 01/01/1977

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MARK PICK

(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,775	7,567	20,069	49,411	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,775	7,567	20,069	49,411	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.60%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 13,522

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	334,013	25,322	16,462	375,797		375,797		375,797			1
2	Food Purchase		233,127		233,127		233,127	(858)	232,269			2
3	Housekeeping	316,523	50,589		367,112		367,112		367,112			3
4	Laundry	84,384	30,280		114,664		114,664		114,664			4
5	Heat and Other Utilities			238,682	238,682		238,682		238,682			5
6	Maintenance	86,044	107,988	36,136	230,168		230,168		230,168			6
7	Other (specify):*			28,901	28,901		28,901		28,901			7
8	TOTAL General Services	820,964	447,306	320,181	1,588,451		1,588,451	(858)	1,587,593			8
	B. Health Care and Programs											
9	Medical Director			79,750	79,750		79,750		79,750			9
10	Nursing and Medical Records	3,455,380	121,145	186,861	3,763,386	52,915	3,816,301		3,816,301			10
10a	Therapy	1,623,452		600	1,624,052		1,624,052		1,624,052			10a
11	Activities	149,513	7,669	1,124	158,306		158,306		158,306			11
12	Social Services	96,959			96,959		96,959		96,959			12
13	CNA Training											13
14	Program Transportation			1,885	1,885		1,885		1,885			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,325,304	128,814	270,220	5,724,338	52,915	5,777,253		5,777,253			16
	C. General Administration											
17	Administrative	233,558		215,200	448,758		448,758	(22,533)	426,225			17
18	Directors Fees											18
19	Professional Services			243,161	243,161	(52,915)	190,246	(710)	189,536			19
20	Dues, Fees, Subscriptions & Promotions			118,249	118,249		118,249	(66,697)	51,552			20
21	Clerical & General Office Expenses	688,680	62,032	54,740	805,452		805,452	(219,997)	585,455			21
22	Employee Benefits & Payroll Taxes			1,072,420	1,072,420		1,072,420	(1,573)	1,070,847			22
23	Inservice Training & Education			8,874	8,874		8,874		8,874			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			23,275	23,275		23,275	(12,207)	11,068			25
26	Insurance-Prop.Liab.Malpractice			233,330	233,330		233,330		233,330			26
27	Other (specify):*							14,354	14,354			27
28	TOTAL General Administration	922,238	62,032	1,969,249	2,953,519	(52,915)	2,900,604	(309,363)	2,591,241			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,068,506	638,152	2,559,650	10,266,308		10,266,308	(310,221)	9,956,087			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BALLARD NURSING CENTER #0023093 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	16,462	
	REPAIRS & MAINTENANCE		0	
			0	16,462
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		91,759	
	ELECTRICITY		89,070	
	WATER		52,013	
	CABLE TV - LOBBY		5,840	
			0	238,682
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		14,058	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	CONTRACTED BLDG MAINT		16,965	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,113	
	FIRE SERVICE		0	
			0	
			0	
			0	36,136
7	**OTHER**			
	SCAVENGER		28,901	
	SECURITY SERVICE		0	28,901
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	79,750	79,750

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	177,289	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,872	
	PHARMACY CONSULTANT	XVIII B 39-2	5,700	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	186,861
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	600	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	600
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,124	
			0	1,124
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BALLARD NURSING CENTER #0023093 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,885	1,885
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	215,200	215,200
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	71,241	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	171,920	
			0	243,161
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	6,929	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	58,408	
	EMPLOYEE WANT ADS	XIX F	18,603	
	CONTRIBUTIONS	VI 20 XIX F	1,360	
	DUES & SUBSCRIPTIONS	XIX F	16,038	
	LICENSES & PERMITS	XIX F	14,191	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,720	118,249
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,719	
	COMPUTER EXPENSE		1,750	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,337	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		46,934	
	MESSENGER SERVICE		0	
			0	54,740

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	397,733	
	UNEMPLOYMENT COMPENSATION	XIX D	225,850	
	WORKERS COMPENSATION INSURANCI	XIX D	96,439	
	HOSPITALIZATION INSURANCE	XIX D	344,953	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,872	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	1,573	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	1,072,420
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		8,874	8,874
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		23,275	23,275
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		233,330	233,330
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 2,559,650

BALLARD NURSING CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	233,127	PATIENT MEALS	148233
LESS SALES TAX	(858)	ADD EMPLOYEE MEALS	0
NET FOOD	232,269	TOTAL MEALS/YEAR	148233
TOTAL PATIENT CENSUS	49,411	NET FOOD	232269
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	148233
TOTAL PATIENT MEALS	148233	COST PER MEAL	1.57
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number BALLARD NURSING CENTER #0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			210,673	210,673		210,673	168,262	378,935			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			183,852	183,852		183,852	661,172	845,024			32
33	Real Estate Taxes							356,645	356,645			33
34	Rent-Facility & Grounds			1,214,550	1,214,550		1,214,550	(1,214,250)	300			34
35	Rent-Equipment & Vehicles			36,846	36,846		36,846		36,846			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,645,921	1,645,921		1,645,921	(28,171)	1,617,750			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,296,102	72,748	1,368,850		1,368,850		1,368,850			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,296,102	199,221	1,495,323		1,495,323		1,495,323			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,068,506	1,934,254	4,404,792	13,407,552		13,407,552	(338,392)	13,069,160			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(62,752)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(858)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,337)	21		18
19	Entertainment	(6,929)	20		19
20	Contributions	(1,360)	20		20
21	Owner or Key-Man Insurance	(1,573)	22		21
22	Special Legal Fees & Legal Retainers	(4,433)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(58,408)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(229,867)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (368,517)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	30,125		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 30,125		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (338,392)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BALLARD NURSING CENTER

ID# 0023093

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	NON ALLOWABLE STAFF TRANSPORTATION	(12,207)	25	2
3	MARKETING SALARIES	(217,660)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(229,867)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(858)	0	0	0	0	0	0	0	0	0	0	(858)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(858)	0	0	0	0	0	0	0	0	0	0	(858)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(22,533)	0	0	0	0	0	0	0	0	(22,533)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,433)	2,500	1,223	0	0	0	0	0	0	0	0	(710)	19
20	Fees, Subscriptions & Promotions	(66,697)	0	0	0	0	0	0	0	0	0	0	(66,697)	20
21	Clerical & General Office Expenses	(219,997)	0	0	0	0	0	0	0	0	0	0	(219,997)	21
22	Employee Benefits & Payroll Taxes	(1,573)	0	0	0	0	0	0	0	0	0	0	(1,573)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(12,207)	0	0	0	0	0	0	0	0	0	0	(12,207)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	14,354	0	0	0	0	0	0	0	0	14,354	27
28	**TOTAL General Administration**	(304,907)	2,500	(6,956)	0	0	0	0	0	0	0	0	(309,363)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(305,765)	2,500	(6,956)	0	0	0	0	0	0	0	0	(310,221)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(62,752)	227,983	3,031	0	0	0	0	0	0	0	0	168,262	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	661,172	0	0	0	0	0	0	0	0	0	661,172	32
33	Real Estate Taxes	0	356,645	0	0	0	0	0	0	0	0	0	356,645	33
34	Rent-Facility & Grounds	0	(1,214,250)	0	0	0	0	0	0	0	0	0	(1,214,250)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(62,752)	31,550	3,031	0	0	0	0	0	0	0	0	(28,171)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(368,517)	34,050	(3,925)	0	0	0	0	0	0	0	0	(338,392)	45

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ELI PICK	32.5	N/A		BALLARD PARTNERS		BUILDING OWNEI
MOSHE PICK	35			PICK MGMT GROUP		MGMT CO
HADASSAH PICK	20					
SARAH FITTERMAN	10					
GLORIA PRUZAN	2.5					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,214,250	BALLARD PARTNERS		$	$ (1,214,250)	1
2	V								2
3	V	19	ACCOUNTING FEES		" " "		2,500	2,500	3
4	V	30	DEPRECIATION		" " "		227,983	227,983	4
5	V	32	INTEREST		" " "		661,172	661,172	5
6	V	33	REAL ESTATE TAX		" " "		356,645	356,645	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,214,250			$ 1,248,300	$ * 34,050	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 215,200	PICK MANAGEMENT GROUP	100.00%	$	$ (215,200)	15
16	V								16
17	V	17	SALARIES		" "		192,667	192,667	17
18	V	19	DATA PROCESSING		" "		1,223	1,223	18
19	V	27	PAYROLL TAXES		" "		14,354	14,354	19
20	V	30	DEPRECIATION		" "		3,031	3,031	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 215,200			$ 211,275	$ * (3,925)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MOHE PICK	EXECUTIVE DIR	ADMINISTRATIV	35.00	NONE	40	100.00	SALARY	$ 96,333	17-7	1
2	ELI PICK	EXECUTIVE DIR	ADMINISTRATIV	32.50	NONE	40	100.00	SALARY	96,333	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 192,666		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	ALLFIRST		X	MORTGAGE	$62,766.00	5/91	$	$ 9,107,120	8/34	10.5000	$ 661,172	1
2												2
3												3
4												4
5												5
	Working Capital											
6	NEW CENTURY		X	WORKING CAPITAL				2,197,119			163,209	6
7	CAPITALIZE LEASE		X	EQUIPMENT				154,135			16,823	7
8	INSURANCE FINANCING		X	INSURANCE				102,762			3,820	8
9	TOTAL Facility Related				$62,766.00		$	$ 11,561,136			$ 845,024	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 11,561,136			$ 845,024	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BALLARD NURSING CENTER **#** 0023093 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	358,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	353,645	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,355)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	361,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 2,023 **For** 1997 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	(2,023)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	354,622	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	360,457	8
2001	346,499	9
2002	350,873	10
2003	350,950	11
2004	353,645	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BALLARD NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023093

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-303-013-0000	NURSING HOME	$ 353,645.01	$ 353,645.01
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 353,645.01	$ 353,645.01

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		1991	1973	$ 2,851,196	$ 94,836	35	$ 90,514	$ (4,322)	$ 1,367,809	4
5				1994	995,072	25,515	35	25,515		296,612	5
6				1994	986,459	25,294	35	25,294		281,396	6
7				1995	101,526	2,603	35	2,603		27,440	7
8											8
	Improvement Type**										
9	VARIOUS			1980	2,955		20			2,955	9
10	VARIOUS			1981	11,619		20			11,619	10
11	VARIOUS			1982	17,413		20			17,413	11
12	VARIOUS			1984	3,536		20			3,536	12
13	VARIOUS			1985	8,040		20			8,040	13
14	VARIOUS			1986	18,668		20	484	484	18,668	14
15	VARIOUS			1987	42,109	722	20		(722)	42,109	15
16	VARIOUS			1988	15,834	350	20	373	23	15,576	16
17	VARIOUS			1990	4,990	158	20	250	92	3,938	17
18	VARIOUS			1991	155,172	7,257	20	8,760	1,503	126,750	18
19	VARIOUS			1992	54,689	1,274	20	2,734	1,460	36,711	19
20	VARIOUS			1993	1,571	50	20	77	27	982	20
21	HEATING COOLING SYSTEM			1996	2,312	59	20	116	57	1,112	21
22	INTERIOR SIGNS			1996	350	9	20	18	9	172	22
23	BUILDING IMPROVEMENT			1996	70,114	1,798	20	3,506	1,708	33,599	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR SYSTEM BALANCE	1996	$ 1,762	$ 297	20	$ 88	$ (209)	$ 843	37
38	MAV MOTOR REPLACEMENT	1996	2,000	51	20	100	49	958	38
39	INTERIOR SIGNS	1996	663	17	20	33	16	316	39
40	DRAPES	1996	616	16	20	31	15	297	40
41	COMP STATION CABLE	1996	2,566	66	20	128	62	1,227	41
42	HEAT AND COOLING SYSTEM	1997	2,999	77	20	150	73	1,250	42
43	SEWAGE PUMP	1997	2,498	64	20	125	61	1,083	43
44	CAULKING	1998	5,845	150	20	292	142	2,093	44
45	RENOVATION PATIOS	1998	6,134	157	20	307	150	2,303	45
46	A/C REPAIRS	1998	2,124	54	20	106	52	804	46
47	PARKING LOT	1998			20				47
48	ALARM SYSTEM	1998	2,500	64	20	125	61	990	48
49	SEWAGE PUMP	1998	2,498	64	20	125	61	1,000	49
50	A/C COUPLINGS	1998	2,905	74	20	145	71	1,112	50
51	PATIO FLOOR	1998	2,040	52	20	102	50	757	51
52	MOTOR	1998	1,544	40	20	77	37	603	52
53	SPRINKLER SYSTEM	1998	3,500	90	20	175	85	1,298	53
54	FAUCETS, COUPLINGS	1998	10,159	260	20	508	248	3,810	54
55	COMPRESSORS	1998	13,886	356	20	694	338	5,089	55
56	MEDICAL GAS PIPING	1999	124,600	3,195	20	6,230	3,035	42,053	56
57	ELECTRICAL WORK	1999	201,699	5,172	20	10,085	4,913	69,755	57
58	CHILLER REPLACEMENT	1999	76,355	1,958	20	3,818	1,860	25,453	58
59	AIR CARRIER	1999	693	18	20	35	17	213	59
60	CARPETING	1999	4,921	126	20	492	366	3,403	60
61	LOADING RAMP & PATIO	1999	127,175	3,261	20	6,359	3,098	42,923	61
62	SPRINKLER REPAIRS	1999	2,850	73	20	143	70	906	62
63	HEATING AND COOLING	1999	8,208	210	20	410	200	2,528	63
64	FLOW DEVICE OXYGEN	1999	1,760	45	20	88	43	587	64
65	ER GENER DESIGN	1999	11,614	298	20	568	270	3,976	65
66	DOOR CENSORS	1999	718	18	20	36	18	231	66
67	SIGNS	1999	18,235	468	20	912	444	6,080	67
68	METAL INCLOSURE	1999	934	24	20	47	23	282	68
69	PARKING AND AISLE PAVE	1999	65,443	1,678	20	3,272	1,594	21,615	69
70	TOTAL (lines 4 thru 69)		$ 6,055,069	$ 178,418		$ 196,050	$ 17,632	$ 2,542,275	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,055,069	$ 178,418		$ 196,050	$ 17,632	$ 2,542,275	1
2	NURSE CALL SYSTEM	1999	49,222	1,262	20	2,461	1,199	16,202	2
3	LOAD RAMP DESIGN	1999	14,368	368	20	718	350	4,847	3
4	DOOR LOCKS	1999	2,781	71	20	139	68	880	4
5	FIRE PANEL	1999	978	25	20	49	24	323	5
6	NURSE CALL SYSTEM	2000	49,221	1,262	20	2,461	1,199	14,356	6
7	KEYLESS ENTRY SYSTEM	2000	1,250	32	20	62	30	364	7
8	ELECTRICAL OUTLETS	2000	7,600	195	20	380	185	2,026	8
9	VENTILATION BOILER	2000	5,696	146	20	284	138	1,468	9
10	WEIL MCLAIN BOILER	2000	50,425	1,293	20	2,521	1,228	10,504	10
11	HOT WATER BOILER	2000	9,172	235	20	459	224	2,142	11
12									12
13	TELEPHONE SYSTEM	1999	83,381	2,138	20	4,169	2,031	55,587	13
14	TELEPHONE SYSTEM ENHANCEMENT	2000	1,716	44	10	172	128	1,032	14
15									15
16	PICK MGMT GROUP	1996	48,986	1,256	20		(1,256)	49,896	16
17									17
18	DIALYSIS SPACE/MEDICAL &GAS UPGRADES	2001	33,596	1,222	27.5	1,221	(1)	5,529	18
19	COOLING COIL REPLACEMENT	2001	24,604	894	27.5	895	1	4,065	19
20									20
21	BOILER	2002	49,501	1,800	20	2,475	675	8,663	21
22	VALVES/BOOSTER PUMP	2002	2,430	88	20	122	34	427	22
23	DIALYSIS ROOM	2002	89,870	3,268	20	4,494	1,226	15,729	23
24	REMOVE & REPAPER	2002	10,972	399	20	549	150	1,921	24
25	FLORING/DRAPERIES	2002	27,204	979	20	1,360	381	5,988	25
26									26
27	ELEV CAB REPLACEMENT	2003	6,850	249	27.5	249		612	27
28	REPAIR FLUE / REMOVE & REPACE GREASE TRAP	2003	12,463	453	27.5	453		1,114	28
29	BLINDS	2003	1,760	64	27.5	64		157	29
30	REPAIR AIR HANDLER/REPLACE DIGITAL TERMOSTAT	2003	5,690	207	27.5	207		509	30
31	DOORS	2003	1,387	51	27.5	51		125	31
32	SIDEWALK REPAIRS	2003	800	29	27.5	29		72	32
33	HOT WATER BOILER	2003	29,001	1,055	27.5	1,055		2,945	33
34	TOTAL (lines 1 thru 33)		$ 6,675,993	$ 197,503		$ 223,149	$ 25,646	$ 2,749,758	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,675,993	$ 197,503		$ 223,149	$ 25,646	$ 2,749,758	1
2	CARPET	2004	5,459	1,856	5	1,092	(764)	1,911	2
3	SEWER LINE REPLACEMENT	2004	2,385	87	27.5	87		127	3
4	FIRE SUPPRESSION SYSTEM	2004	2,579	94	27.5	94		137	4
5	ELEVATOR CAB REPLACEMENT	2004	6,850	249	27.5	249		363	5
6	CARPETING	2005	57,619	960	27.5	960		960	6
7	PLUMBING	2005	1,636	27	27.5	27		27	7
8	WINDOW TREATMENT	2005	1,783	30	27.5	30		30	8
9		2005	610,957	10,183	27.5	10,183		10,183	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,365,261	$ 210,989		$ 235,871	$ 24,882	$ 2,763,496	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 925,717	$ 149,581	$ 92,572	$ (57,009)		$ 351,109	71
72	Current Year Purchases	232,765	46,553	23,276	(23,277)		23,276	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	2,494,216	31,448	24,100	(7,348)			74
75	TOTALS	$ 3,652,698	$ 227,582	$ 139,948	$ (87,634)		$ 374,385	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,017,959	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 438,571	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 375,819	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (62,752)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,137,881	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 36,846 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BALLARD NURSING CENTER STATE OF ILLINOIS # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 7,546	$		$ 7,546	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			58,764			58,764	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			6,438			6,438	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				730,541		730,541	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RESPIRATORY, RADIOL, LAB, RENT Other (specify): SUPPLIES, OXYGEN	39-2					565,561		565,561	13
14	TOTAL			$		$ 72,748	$ 1,296,102		$ 1,368,850	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (8,400))	3,905,297		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	212,582		6
7	Other Prepaid Expenses	127,773		7
8	Accounts Receivable (owners or related parties)	585,478		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,831,130	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	718,217		15
16	Equipment, at Historical Cost	1,158,481		16
17	Accumulated Depreciation (book methods)	(766,958)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,109,740	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,940,870	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,644,714	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,351,254		29
30	Accrued Salaries Payable	410,433		30
31	Accrued Taxes Payable (excluding real estate taxes)	102,925		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	10,513		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,519,839	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,020,437		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,020,437	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,540,276	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 400,594	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,940,870	$	48

*(See instructions.)

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 339,695	1
2	Restatements (describe):		2
3		1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 339,696	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	60,898	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 60,898	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 400,594	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,499,159	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,499,159	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	938,980	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 938,980	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,015	13
14	Non-Patient Meals	5,646	14
15	Telephone, Television and Radio	4,888	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 25,549	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,946	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,946	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS - NET	877	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 877	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,469,511	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,588,451	31
32	Health Care	5,724,338	32
33	General Administration	2,953,519	33
	B. Capital Expense		
34	Ownership	1,645,921	34
	C. Ancillary Expense		
35	Special Cost Centers	1,368,850	35
36	Provider Participation Fee	126,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,407,552	40
41	**Income before Income Taxes (line 30 minus line 40)****	61,959	41
42	**Income Taxes**	(1,061)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 60,898	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	2,514	2,714	252,881	93.18	2
3	Registered Nurses	36,985	40,969	1,318,907	32.19	3
4	Licensed Practical Nurses	26,426	30,494	382,128	12.53	4
5	CNAs & Orderlies	93,438	101,527	1,471,930	14.50	5
6	CNA Trainees					6
7	Licensed Therapist	39,606	42,760	1,556,255	36.40	7
8	Rehab/Therapy Aides	3,375	3,739	67,197	17.97	8
9	Activity Director	1,701	1,966	32,262	16.41	9
10	Activity Assistants	9,913	10,772	117,251	10.88	10
11	Social Service Workers	4,501	4,856	96,959	19.97	11
12	Dietician					12
13	Food Service Supervisor	1,755	2,052	41,373	20.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,541	31,853	292,640	9.19	15
16	Dishwashers					16
17	Maintenance Workers	4,970	5,242	86,044	16.41	17
18	Housekeepers	30,861	33,645	316,523	9.41	18
19	Laundry	7,595	8,394	84,384	10.05	19
20	Administrator	2,552	2,760	233,558	84.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,328	26,212	688,680	26.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,896	1,967	29,534	15.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	321,957	351,922	$ 7,068,506 *	$ 20.09	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 16,462	1-3	35
36	Medical Director		79,750	9-3	36
37	Medical Records Consultant		3,872	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		5,700	10-3	39
40	Physical Therapy Consultant		600	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		1,124	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 107,508		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN DUDEK	ADMIN		$ 101,479
SUSAN MIKALS AHLGREN	ADMIN		132,079
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 233,558

B. Administrative - Other

Description	Amount
PICK MANAGEMENT	$ 215,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 215,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		243,161
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 243,161

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 96,439
Unemployment Compensation Insurance		225,850
FICA Taxes		397,733
Employee Health Insurance		344,953
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		5,872
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		1,573
INSURANCE - EXECUTIVE LIFE	VI 21	(1,573)
TOTAL (agree to Schedule V, line 22, col.8)		$ 1,070,847

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,795
Advertising: Employee Recruitment	18,603
Health Care Worker Background Check	2,720
(Indicate # of checks performed 136)	
MARKETING/ADV/PROMO	65,337
TRUST/FRANCHISE/CONTRIB/ETC	1,360
LICENSES & PERMITS	8,396
DUES & SUBSCRIPTIONS	16,038
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(1,360)
Less: Public Relations Expense	(6,929)
Non-allowable advertising	(58,408)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,552

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BALLARD NURSING CENTER # 0023093 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE - $13,860**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,276** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **126,473**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees